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FOSTER CARE ADVISORY PANEL

PRELIMINARY REPORT

EXECUTIVE SUMMARY

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In May 1988, Human Services Secretary Philip W. Johnston appointed a five person panel to review systemic policy and organizational issues raised as a result of the deaths of two young children in the same foster home within a three month period. These systemic issues included: the monitoring and supervision of children who are in foster care; the relationship between public and private foster care placement agencies; the supervision of foster parents and children; the exchange of information between state agencies; and protocols for child deaths and serious injuries.

The Panel was not asked to review the specific circumstances surrounding the deaths because of the ongoing inquest being conducted by the Roxbury District Court. All materials concerning the deaths were turned over to the Suffolk County District Attorney and, at his request and consistent with court order, could not be provided to the group pending the inquest. Secretary Johnston fully supported the inquest as the appropriate means to investigate the circumstances of the deaths.

The Panel was composed of five child welfare experts: Maria Mossaides, General Counsel, Office of the Comptroller, former Acting Director of the Office for Children and former Deputy General Counsel for Department of Social Services; Joseph Leavey, M.S.W., Executive Director, Communities for People and former Commissioner of the Department of Youth Services; Father Richard Craig, M.S.W., Archdiocesan Director of Catholic Charitable Bureau of the Archdiocese of Boston; Toni Lewis, M.S.W., Program Director, MSPCC, Social Worker, Massachusetts Society for the Prevention of Cruelty to Children; Ron Floridaia, foster parent, representing the Massachusetts Foster Parent Association. The Panel was chaired by Nancy K. Kaufman, M.S.W., Assistant Secretary for Social and Mental Health Services, EOHS. Legal and staff support was provided by Edith Howe, Acting General Counsel, EOHS; Richard Jobin, M.S.W., Director of Children's Services, EOHS; and Mary Ann Nee, Boston Juvenile Court Liaison, EOHS.

The Panel met eight times between May 17 and June 29. The initial charge to the Panel was to review and make recommendations about the following:

1. Information-sharing between state agencies and between public and private agencies.
2. Procedures and protocols concerning deaths and serious injuries of children in foster care.

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3. The relationship between DSS/OFC and private foster care placement agencies; and
4. The adequacy of existing systems for reviewing and monitoring foster placements including:

Foster Care Review
Professional Advisory Committee
OFC/DSS Statutes and Regulations
Training and Supervision.

The attached report summarizes and makes recommendations on each of these areas. Key recommendations are highlighted below.

1. Statutes which have created barriers to information-sharing should be amended to clarify that DSS may share relevant information with OFC and other state agencies which serve or protect children.
2. Information obtained from DSS by other state agencies should be maintained as confidential information to protect the privacy of individuals involved.
3. DSS should develop written protocols outlining the responsibility of a DSS area office in the investigation and assessment of risk to other children in the home in cases of death or serious injury of children in foster care.
4. All deaths or serious injuries of children in foster care should be reported to OFC.
5. DSS regulations and contracts should be amended to include specific language which clarifies the roles of social workers and other child care professionals in the delivery and monitoring of children in foster care. Workers in agencies which contract with DSS should be subject to the same policies and regulations as DSS workers.
6. Appropriate OFC and DSS regulations should be amended to require that foster homes are regularly monitored and any significant changes in the household documented (e.g. health problems of family members, etc.)
7. DSS should be required to comply with the same OFC licensure standards as private foster care placement agencies.

8. Questions regarding compliance by state agencies with OFC regulations should be immediately reported to and resolved by EOHS.
9. Foster care review should be expanded to include close review of medical passports and to increase the level of participation of foster parents.
10. The role of the homefinder/family resource worker as a primary support to foster parents should be strengthened and enhanced to include more training, participation in foster care review and establishment of caseload standards.
11. Training of social work staff and foster parents should be expanded to increase understanding of racial, ethnic and linguistic minority and cultural issues.
12. Foster parents should be provided with a variety of supports including: around-the-clock, community-based support, and increased training.
13. DSS should increase its training of mandated reporters and develop a notification system to remind professionals of their responsibilities as mandated reporters when they are re-licensed.
14. By January 1989, DSS should raise its medical passport compliance to 100%.
15. The DSS Professional Advisory Committee should continue to review all DSS investigative reports of children who have died in foster care.
16. The DSS Interagency Agreement with the Chief Medical Examiner should be strictly enforced and monitored.

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PRELIMINARY REPORT

INTRODUCTION

In May 1988, Human Services Secretary Philip W. Johnston appointed a five person panel to review systemic policy and organizational issues raised as a result of the deaths of two young children in the same foster home within a three month period. These systemic issues included: the monitoring and supervision of children who are in foster care, the relationship between public and private foster care placement agencies; the supervision of foster parents and children; the exchange of information between state agencies, and protocols for child deaths and serious injuries.

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The Panel was comprised of five child welfare experts. It included: Ron Floridia, foster parent, representing the Massachusetts Foster Parent Association; Joseph Leavey, M.S.W. Executive Director, Communities for People and former Commissioner of the Department of Youth Services; Father Richard Craig, M.S.W., Archdiocesan Director of Catholic Charitable Bureau of the Archdiocese of Boston; Toni Lewis, M.S.W., Program Director, MSPCC, Social Worker, Massachusetts Society for the Prevention of Cruelty to Children; Maria Mossaides, General Counsel, Office of the Comptroller, former Acting Director of the Office for Children and former Deputy General Counsel for the Department of Social Services. The Panel was chaired by Nancy K. Kaufman, M.S.W., Assistant Secretary for Social and Mental Health Services, EOHS. Legal and staff support was provided by Edith Howe, Acting General Counsel, EOHS; Richard Jobin, M.S.W., Director of Children's Services, EOHS; and Mary Ann Nee, Boston Juvenile Court Liaison, EOHS.

The Panel met eight times between May 17th and June 29th. At three of these meetings the Commissioners of Social Services and Office for Children were interviewed. The initial charge to the Panel was to review and to make recommendations concerning the following:

1. Information sharing between state agencies and between public and private agencies.;
2. Procedures and protocols concerning deaths and serious injuries of children in foster care;
3. The relationship between DSS/OFC and private foster care placement agencies; and
4. The adequacy of existing systems for reviewing and monitoring foster placements including:

Foster Care Review
Professional Advisory Committee
OFC/DSS Statutes and Regulations
Training and Supervision

To obtain a broad base of information from child welfare advocates, Nancy Kaufman and members of the Panel met with advocates to seek their advice and to include their perspective in the Panel's process. Panel members also consulted with a variety of individuals in the legal, child welfare, and provider community.

The Panel reviewed regulations, statutes and policies of the agencies that related to foster care, foster care review, information-sharing, the DSS Case Investigations Unit, and training and supervision. A partial list of materials reviewed include:

- . OFC statute, G.L.c. 28A
- . OFC licensing regulations for foster care placement agencies, 102 CMR 4.00
- . DSS statutes, G.L.c. 18B, G.L.c. 119, ss. 51A-F
- . DSS regulations for the Case Investigative Unit, 110 CMR 13.00
- . DSS/OFC interagency agreement

- . Interagency agreement between DSS and the Office of the Chief Medical Examiner
- . DSS Case Practice Manual, DSS job descriptions and monthly management reports
- . Fair Information Practices Act, G.L.c. 66A

(A complete listing of materials is included in the appendix.)

The Panel reviewed these materials to determine which policies and systems were currently in place for the foster care system and whether such systems were being appropriately implemented. After reviewing the written materials, the Panel prepared a list of questions for OFC Commissioner Mary Kay Leonard and DSS Commissioner Marie Matava. The Commissioners were also asked to submit their own issues to the Panel. The Panel met with each Commissioner to review their responses to the questions.

As a result of discussions during the eight advisory panel meetings, the review of written materials, the meetings with OFC and DSS Commissioners, and advice from child advocates, the Panel makes the following recommendations.

I. REVIEW OF EXISTING SYSTEMS

1. Contract Relationship Between DSS and Non-Profit/Private Agencies

DSS has provided foster care services to children by either placing children in DSS-selected foster homes or by contracting with private placement agencies to provide these services. In some cases where a private placement agency has been utilized, these agencies have been responsible for the recruitment, screening, training, and supervision of the foster parents, while the DSS social worker has been responsible for the placement and monitoring of the child within the home.

The Panel has identified a number of problems with this arrangement in which responsibility for the foster home and the foster child is shared by two different agencies. Questions were raised about how much the DSS worker and the private agency workers communicate about the foster home and the child, which case practice standards and procedures are utilized, who is in charge when there is a problem in the foster home, and how DSS monitors these arrangements.

The Panel was informed by DSS that in an effort to address these issues and the problem of obtaining consistency in the services it purchases, in June, 1987, DSS developed a Full Time Equivalent (FTE) pilot model under which DSS has purchased complete casework services, including both foster home and social work services, from private agencies. Under this pilot model, selected private providers have followed the same standards of practice as DSS workers, have carried the same number of cases, and have adhered to the same regulations and policies that govern DSS. These contracts have been monitored by DSS area and regional contract monitors who visit the private agencies and review agency records and procedures.

Recommendations

- o The Panel strongly endorses the idea of having one private agency be responsible for both the foster home and the child as proposed in the DSS FTE model when DSS contracts with private agencies for foster care services. However, the Panel recommends that DSS develop systems to closely monitor the services delivered by private agencies through these contracts and strictly enforce compliance with the terms of these contracts;
- o All private placement agencies which contract with DSS should be required to follow DSS regulations and the DSS case practice manual;
- o To improve and to ensure appropriate monitoring of these contracts, the DSS area and regional contract monitors should conduct site visits, examine provider caseloads and compliance with timelines set by DSS regulations, and all other factors that affect the well-being of children. The monitors should examine randomly selected cases from each provider to review the quality of casework, use of appropriate resources and adequacy of record keeping;

- o In cases where DSS continues to contract with private placement agencies for foster home services only, such contracts should be amended to clarify pursuant to OFC regulations 102 CMR 4.05 (5)(f), the respective roles of DSS and private agency workers, to establish clear guidelines for monitoring foster homes and children in foster care, to ensure equal access to relevant information by all agencies, and to specify that all workers involved in the same families communicate on a regular basis; and
- o A full report on all provider contracts between DSS and foster placement agencies which outlines DSS plans to implement the recommendations of the Panel should be submitted to the Secretary of EOHS within 60 days.

2. Staff Roles and Responsibilities

To ensure the protection of children in foster care and to maintain the quality of foster homes, DSS has implemented a team management approach which includes the child's social worker, the homefinder/family resource worker and the foster parents. The purpose of the team is to ensure that when placement outside the home becomes necessary, children will be guaranteed the most appropriate foster home to meet their needs. Under this system, foster parents are to be provided with the necessary supports to maintain a quality home, and homefinders/family resource workers, social workers and foster parents are to be trained to understand each other's roles and supervised to assure consistency in the interpretation of policies and regulations.

In order to provide quality care to children, good communication between members of this team is essential. In addition, the team must have an in-depth understanding of the diversity of racial, ethnic and linguistic minority and cultural issues.

a. Homefinder/Family Resource Worker:

According to DSS policies and practice, the Homefinder/Family Resource Worker is the case manager for the foster parent and is responsible for recruitment, training, monitoring and responding to general foster family concerns. The homefinder/family resource worker is intended to be the main support system for the foster family. Although the child's social worker has the primary responsibility for the child, the homefinder is often contacted when the social worker has difficulty in resolving a child-related problem within the foster home. In these circumstances,

the homefinder/family resource worker acts as a facilitator, and provides support, information, and assists with problem solving. The continuing relationship between a foster parent and DSS is most often through the homefinder/family resource worker, however, the Panel was informed that foster parents believe that generally they do not have enough access to these workers. DSS regulations require only that foster homes be evaluated annually. 110 CMR 7.113. There appears to be no other requirement that these workers regularly visit or conduct on-going monitoring of foster homes other than at these yearly evaluations. In addition, the role of homefinder/family resource worker has historically not received the same attention or resources as other professional DSS staff, despite the essential role that homefinders/family resource workers play as the link between the department and the foster parents.

Recommendations

- o DSS and OFC should amend appropriate regulations or take other administrative action to require that homefinders/family resource workers regularly visit and monitor each foster home and document any significant changes in the home such as death, divorce, serious illness, etc.;
- o All such significant changes should be communicated immediately to the child's social worker;
- o DSS should implement systems to support and enhance the role of the homefinder/family resource worker. Caseload standards for homefinders/family resource workers should be established as well as standards for the frequency of home visits to a foster home;
- o The homefinder/family resource worker job description should be rewritten to further delineate the critical supportive role they are expected to provide to foster parents;
- o The homefinder/family resource worker should be invited to attend periodic Foster Care Reviews to support foster parents, to assist in the monitoring of the home, and to increase their understanding of placement issues; and
- o Training should be expanded to increase understanding of the racial, ethnic and linguistic minority, and cultural issues involved in foster parenting.

b. Social Workers

Social workers have primary care responsibility for a child in foster care and for maintaining contact with the child's birth family. Social workers are required under OFC regulations to pay monthly visits to the child. 102 CMR 4.08(3). The social worker is also responsible for working with the foster family on any child-specific issues that may arise. The social worker is responsible for providing to the foster parents all necessary materials (service plans, medical passport, etc.). The social worker interacts with and is expected to be a resource to the foster family. The ability to understand the foster parent's concerns and to communicate with the foster parent is essential in offering the child in foster care the best placement possible. The Panel was informed that not all social worker visits take place in the foster home and, therefore, not every foster home is visited monthly.

Recommendations

- o DSS and OFC should amend appropriate regulations or take other administrative action to clarify that social workers must visit the foster home on at least a monthly basis. Such visits should include a review of the child's medical passport;
- o DSS regulations or case practice manuals should be amended to require that social workers regularly communicate with homefinder/family resource workers and inform them of any significant changes in the foster home; and
- o Training should continue to be implemented for all DSS social workers which parallels the training currently provided to new foster parents. Such training should enhance the workers' understanding of the foster parent's role and it should include training on racial, ethnic and linguistic minority and cultural issues.

c. Foster Parents

Foster parents are the most important members of the foster care team. However, the Panel was informed of situations in which foster parents were not fully supported by the other members of the team. For example, in some cases foster parents received no medical information or service plans for children placed in their homes, despite evidence of clear medical problems.

The Panel concluded that communication between foster parents and the other members of team required improvement. It appeared that foster parents require more support and information about children in their care and that DSS workers needed to be updated more regularly by foster parents about any changes in the foster home. For example, currently, there is no regulatory requirement that foster parents provide regular updates to the team about any changes in the home which have occurred since the annual evaluation.

Recommendations

- o Consistent with the recommendations of the Foster Care Commission Report issued in early 1987, an after-hours support system for foster parents should be implemented as soon as possible with sufficient English and non-English speaking staff to respond to emergencies and to provide community-based support to the foster parents;
- o Foster parents need a variety of community-based support systems available around the clock in order to ensure the continued quality of care and to help prevent "burnout". A community-based system of support for foster parents such as support groups, hotlines, and respite services, should be developed in each DSS area office in cooperation with the Massachusetts Foster Parent Association;
- o DSS should emphasize to the foster parent the important role the homefinder/family resource worker plays in providing the necessary support and encouragement to foster parents. Efforts should continue to give foster parents the appropriate recognition for the key role they play in providing substitute homes and quality care for Massachusetts children in foster care and to create an atmosphere of mutual respect between social workers and foster parents;

- o Participation of foster parents in Foster Care Reviews should be encouraged;
- o Training for foster parents which is now provided by DSS to new foster parents should continue to be expanded to include all foster parents, in accordance with DSS and OFC regulations regarding on-going training;
- o Children should be placed, to the maximum extent possible, in similar cultural, ethnic, and racial homes. When this is not possible, training should be provided to assist foster parents with issues related to cultural, ethnic and racial diversity;
- o DSS and OFC regulations providing that foster parents receive all pertinent information regarding the child before placement or immediately after placement should be strictly enforced; and
- o Foster parents should be required by regulation to immediately report to DSS all material changes in the status, health, etc. of household members.

3. Mandated Reporters

General Laws, Chapter 119, Section 51A mandates that certain professionals who work with children report suspected instances of child abuse or neglect to DSS. Some of these mandated professionals include: teachers, social workers, physicians, nurses, hospital personnel, EMTs, police, medical examiners, and day care workers.

The Panel was informed that many of these professionals may not be aware that they are mandated reporters or understand the procedure for making reports to DSS. The Panel believes that there is a need to continually train and educate mandated reporters. Recently, DSS and the Office of the Chief Medical Examiner entered into a written agreement regarding their joint responsibilities under the law and providing for joint training of staff. The Panel believes such efforts to train and coordinate with groups of mandated reporters should be expanded. In addition, on-going training by DSS of school personnel should be expanded.

The Panel also determined that OFC licensors are not specifically listed as mandated reporters under Chapter 119, section 51A. Not all of OFC licensors are social workers or members of other professions which are listed in the statute as mandated reporters. Section 5 of the OFC/DSS Interagency Agreement stipulates that in the course of a review of licensing study OFC employees shall file a 51A report when they suspect child abuse or neglect; however, it appeared that licensors may not be clear about their responsibility to report suspected cases of child abuse or neglect.

Recommendations

- o DSS should organize and offer on-going training for all groups of mandated reporters which should include: the legal obligations of mandated reporters to file a 51A; the 51A screening and investigation process; and how services are provided to families identified by the 51A process;
- o The DSS agreement with the Office of the Chief Medical Examiner should continue to be strictly enforced;
- o DSS should develop a notification form which reminds all mandated reporters of their legal obligations under section 51A, including the appropriate telephone numbers to call to report suspected cases of abuse or neglect;
- o Such notices should be included in mailings to appropriate state-licensed professionals at the time such persons are informed by state boards of registration about renewal of their licenses. DSS should develop strategies to notify other mandated reporters who are not licensed; and
- o Chapter 119, Section 51A should be amended to include OFC licensors as mandated reporters. OFC licensors should receive training on the identification and reporting of suspected cases of child abuse or neglect.

4. The Foster Care Review System

The foster care review system was implemented three years ago by DSS to ensure that the placements of children in foster care are periodically reviewed to determine whether they are necessary and appropriate and whether the service plan developed by DSS for such children includes a plan for permanent placement of the child in his or her biological home or in an adoptive home. Permanency planning is the primary function of this bi-yearly review.

The foster care review is conducted by a three-member panel which includes: a member of the DSS Foster Care Review Unit, a person who may or may not be a DSS employee but not the case worker or supervisor of the case, and a volunteer. According to statute and regulation, the volunteer should be a representative of the various socio-economic, social or ethnic groups served by the panel. The volunteer is trained by the Foster Care Review Unit. In addition to the three panel members, the following people are invited to participate in the review: the family, the child's social worker, the supervisor, the child, if over 14 years of age, foster parents or other substitute care providers, the child's attorney and any other appropriate individuals.

In order to determine the appropriateness of the placement, the team reviews key issues involving the placements. Some of these include: the necessity and appropriateness of the child's continued placement; the necessity and appropriateness of the services to the natural family; the goals of the child's service plan; case activities for the past six months; the projected date by which the child may return to his or her natural parents or guardian or be placed for adoption; and the steps necessary to achieve permanent placement for the child. The review panel is expected to make findings on each of these issues. A report is written and included in the child's record.

The Panel noted three areas for improvement in the foster care review process: the review of medical passports, foster parent participation, and minority participation.

The medical passport system (see Section 6 below) was developed by DSS to ensure that children in foster care received timely and appropriate health care. However, the foster care review currently provides only a limited review of the passport to assure it is up to date. Close review of the passport could be useful in revealing information regarding the adequacy of health care received and in doing permanency planning. It also appeared that health care concerns raised at the review were not always referred immediately to the supervisor and child's social worker, if they were not present at the meeting.

Foster parents could be key members of the review process as they have valuable information to contribute. Foster parents' participation in foster care reviews varies widely across the state. Foster parents were present at about 40% of those case reviews held in FY'87. Factors contributing to the lack of participation include: scheduling concerns, need for babysitters, transportation problems, need for greater understanding of the purpose of foster care review and their role the review.

In addition, participation of appropriate minority representation is not adequately provided for in the reviews.

Recommendations

- o Medical passports should be routinely examined as part of the review process to determine if they are up to date and whether recent health care appointments have been kept. During the review, concerns regarding health care should be documented and immediately referred to the supervisor in the area office;
- o Participation by foster parents in the foster care review process is critical and every effort should be made to ensure their participation. Transportation, scheduling and child care should be arranged to allow the participation of the foster parent; and
- o Foster care review should include at least one person in the review process of the same racial, ethnic or linguistic background as the child to assess the appropriateness of the placement.

5. Professional Advisory Committee (PAC)

The PAC is composed of child welfare professionals and others with the knowledge and experience of the child welfare field. Its role is to give DSS independent professional feedback and advice on case practice, resource and child protection issues. The PAC randomly reviews Case Investigation Unit (CIU) reports of deaths of children who are known to or are in the care and custody of DSS.

The PAC is designed to assure that quality services are delivered to DSS clients and to offer to DSS an objective opinion from outside the agency. The PAC is currently convened four times a year by DSS.

Recommendation

- o For the PAC to be effective and to provide the most comprehensive review of case practices the PAC should allow for more time to review cases;
- o The PAC should continue to review all CIU reports of children who have died while in foster care and have access, when necessary, to full case histories of these children; and
- o The PAC should be expanded to include individuals representing all relevant professional disciplines in order to ensure multi-disciplinary review of cases. This review should be in consultation, when appropriate, with the DSS Family Life Center and the EOHS Investigative Unit.

6. Medical Passport

DSS policy is to provide Project Good Health (PGH) care service or its equivalent to all children in placement either under a voluntary placement agreement or in custody through a court order and living out of home. PGH is a federally funded, medicaid reimbursable program aimed at ensuring that children receive quality, comprehensive health services on a periodic and continual basis.

The medical passport system was developed and implemented by DSS to ensure that children in foster care receive PGH or equivalent health services. The passport documents the child's medical history, such as: chronic ailments or special needs, inoculations, childhood illnesses, allergies, psychological difficulties and dental history. DSS policy requires that this passport be given to the foster parent who maintains custody of the passport while the child is in the home, and be updated regularly by the social worker, based on slips filled out by physicians during medical visits. The Panel was informed, however, that in practice not all foster children were accompanied by their medical passports, and medical passports were not always checked by social workers.

Recommendations

- o By January 1989, DSS should raise their medical passport compliance ratio to 100% to assure that every child who comes into the foster care system has a passport, that it remains with the child in the event that he or she changes placements, and that it is regularly updated;
- o The DSS policy that medical passports be regularly updated by social workers should be strictly enforced;

- o Medical passports should be reviewed during the foster care review to determine if they are complete and to check the timeliness of the last scheduled medical appointments;
- o PGH or equivalent medical encounter forms should be completed and included in the child's case record for all medical visits. DSS should closely monitor compliance with this requirement; and
- o All children should receive an initial medical and dental screening by a health provider within 7 days of entering foster care. Established medical guidelines for routine health care should be strictly followed by DSS.

7. The Office for Children

a. Licensure of Foster Care Placement Agencies

OFC is the state agency mandated to license all public and private foster care placement agencies. As such, OFC provides an additional system of foster care review. As part of its licensing procedures, OFC periodically visits each agency, conducts random reviews of a small number of case files, and visits a small sampling of foster homes.

The Panel noted that despite OFC's mandate to license foster care placement agencies, OFC regulations currently do not require that OFC be notified by these agencies when a child in a foster home dies or is seriously injured. The Panel believes that such information is very relevant to the key monitoring role which OFC plays in the delivery of foster care services to children.

Recommendations

- o OFC should increase the sample size of foster care records reviewed and the number of individual foster parents interviewed during its foster care placement agency licensing/approval process;
- o The OFC licensing/approval process should include a random review of medical passports to determine that comprehensive health services are provided to children in foster care;
- o OFC should define in writing within 60 days, "serious injury" of a child and require that foster care placement agencies report any such incidents to them; and
- o The OFC regulations should require a notification to OFC by all placement agencies in the event of a death or a serious injury to a child in a foster home.

b. OFC as Licensor of DSS

A unique relationship exists between OFC and DSS because of OFC's licensing mandate. Under G.L.c. 28A, s. 10, OFC has the authority to "license" private agencies and "approve" state agencies which provide services to children. According to this statute, public agencies are subject to "the same or higher licensing standards as private placement agencies". Only over the past few years has this statute been strictly interpreted and enforced. Recently, OFC completed the approval process for all 40 area offices of DSS.

The licensing of one state agency by another has raised questions regarding the sharing of information, sanctions for noncompliance, and standards of approval; specifically:

- . Should OFC promulgate separate regulations for the licensing of state agencies or should the same regulation be applied to state agencies that are used for private agencies?
- . What sanctions, if any, can be applied to state agencies by OFC for non-compliance?

Recommendations

- o DSS should continue to be required to follow the same licensing standards as private foster care placement agencies as outlined in OFC regulations, 102 CMR 4.00;
- o OFC should develop written procedures to be followed when there is any question that another state agency is not complying with its standards. Such questions should be immediately reported to and resolved by the Executive Office of Human Services; and
- o OFC should immediately notify EOHS when OFC either refuses to issue, or suspends or revokes a license of a DSS area office.

II. SHARING OF INFORMATION AMONG STATE AGENCIES

After review of the relevant statutes and regulations and interviews with the Commissioners of DSS and OFC, the Panel has concluded that the current system for sharing information about children in foster care requires clarification. State privacy laws and differences of opinion about the construction of those laws have resulted in confusion about how much information DSS can share with OFC or with other agencies which serve DSS families. In light of these findings, the Panel recommends statutory and regulatory changes to facilitate better communication among EOHS agencies which serve children, while still protecting the privacy rights of children and families.

Legal Barriers

Two statutes impose substantial limitations on the ability of DSS to share the information it obtains about children and families with the public and with other state agencies. G.L. c. 66A, the Fair Information Practices Act (FIPA), prohibits state agencies such as DSS from releasing personal data regarding an individual to anyone other than that individual. G.L. c. 66A, s. 2(c). This prohibition extends to other state agencies as well as the public. Id.¹ The only exceptions to this bar to information-sharing are in cases of medical emergencies, when another statute or regulation "consistent with the purposes" of G.L. c. 66A authorizes access to information², or when the individual consents. Id.

While the commissioners of some agencies, such as DMH, are specifically authorized by statute to release information about clients when they judge it to be in the best interest of the client, see, e.g. G.L. c. 123, s. 36, the Commissioner of DSS has no such general authority. The only area where the Commissioner of DSS has clear statutory authority to release information is when a 51A report has been filed. In such instances, she has general discretion to release 51B reports under G.L. c. 119, s. 51E and specific authority to release such reports when they are substantiated and relevant to other state agencies such as OFC under G.L. c. 119, s. 51B(9) and (10).

¹ This prohibition has been strictly interpreted by the courts. In a case involving a lawsuit brought against DSS for sharing information with the Attorney General's office to assist in the defense of another case, the Massachusetts Supreme Judicial Court found that DSS had violated G.L. c. 66A and awarded damages to be paid by DSS. Torres v. Attorney General, 391 Mass. 1(1984).

² This "consistent with the purposes of G.L. c. 66A" standard has not been further clarified by case law. There is disagreement about when a statute or regulation permitting access to information meets this standard.

The net effect of this statutory scheme is that DSS appears to be prohibited from sharing information with OFC and other agencies without client consent unless a 51A report has been filed. While OFC's regulations require all licensed placement agencies, including DSS, to provide OFC with all information required to be kept by OFC under 102 CMR 4:05(4)(h), it is not clear whether that regulation is "consistent with the purposes" of the privacy statute and therefore whether it is fully enforceable. See footnote 2. In cases where a 51A report has been filed, DSS is permitted to share any 51B reports which the Commissioner approves for release as well as certain substantiated 51B reports to OFC, DMH, DYS, and DPH.

Practical Implication for State Agencies

The practical effects of this statutory scheme are particularly problematic for the process of licensing of DSS as a foster care placement agency. Unlike private foster care placement agencies which are not always subject to these laws, DSS appears to be restricted in the information it can provide OFC. For instance, while private placement agencies by informal agreement notify OFC whenever a child in their care has died or been seriously injured, under a strict interpretation of the statute noted above, DSS would be prohibited from sharing such information with OFC unless a 51A report had been filed and substantiated.

The Panel was informed that in light of the good-faith disagreements as to the interpretations of these statutes, the exchange of information between agencies as outlined below has been hampered, particularly for OFC in its role as licenser of DSS:

- . notice to OFC of the death or serious injury of a child in foster care if no report has been filed under G.L. c. 119, s. 51A;
- . notice to OFC of 51A reports which DSS has screened out or does not substantiate when the abuse is alleged to have occurred in a foster home;
- . review by OFC of DSS internal investigations of deaths of foster children including Case Investigative Unit or "CIU" reports;
- . notice to other state agencies (e.g. DMH) providing services to other children in the foster home of the death of a foster child in that home; and
- . access by EOHS to information about children which is maintained by DSS and OFC and which is relevant to the EOHS oversight or investigation of these agencies.

Recommendations

While the Panel believes the purposes of the privacy laws noted above to be worthwhile, it has concluded that they have raised uncertainty and as a result have limited the flow of extremely relevant information between DSS and other state agencies attempting to serve and protect children. The Panel recommends that where areas of ambiguity exist, appropriate statutes be clarified and appropriate administrative action be taken to ensure that:

- o DSS notify OFC when a child in foster care dies or is seriously injured, whether or not a 51A report has been filed;
- o DSS notify OFC on a quarterly basis of total numbers of 51A reports of child abuse alleged to have occurred in foster homes in each DSS area or in each private foster care placement agency;
- o DSS provide OFC with all CIU or any other internal investigation reports concerning foster homes;
- o The DSS Commissioner be given the discretion to release any information about children in DSS care or custody when he or she determines it is in the best interest of the child (see, G.L. c. 123, s. 36); and
- o EOHS have access to DSS and OFC casefiles or investigative reports for purposes of oversight of DSS and OFC.

To assist in the identification of relevant areas of statutory ambiguity, the Panel further recommends that:

- o The EOHS general counsel immediately meet with relevant EOHS agency general counsels to identify which statutes and/or regulations may require amendments to provide agencies with certainty about their legal authority to exchange information, and draft such amendments; and
- o The Secretary of EOHS file such statutory amendments with the legislature and appropriate agency commissioners promulgate such regulatory amendments.

Release of Information Obtained by Agencies from DSS

Licensing or Investigative Reports

The Panel recognizes that the privacy laws prohibiting the sharing of information about children are designed to protect the privacy of children and families who receive services from the state, as well as others whose names appear in data maintained by DSS. The goal of the recommendations in the previous section was to permit DSS to share information with other agencies where it would be used to protect children from harm -- without jeopardizing the privacy rights of individuals involved. The Panel does not intend that this information, once in the possession of these agencies, be released to the public in licensing or investigative reports or other agency documents. Rather, the Panel believes that agencies receiving information from DSS should be bound by the same confidentiality constraints as DSS.

Recommendations

In light of the clear legislative intent to prohibit public release of personal data generally, and of data concerning children who are the subject of child abuse reports in particular, the Panel recommends the following:

- o Appropriate statutes be amended to clarify that personal information about children and other individuals released by DSS to other agencies is confidential;
- o Appropriate interagency agreements between DSS and other state agencies be developed to specify procedures for exactly how information obtained from DSS will be maintained as personal, private information by these agencies; and
- o Agencies which obtain DSS information institute mandatory training for all staff regarding the prohibitions on release of personal data received from DSS.

OFC Communications with Licensees

The Panel also identified the unresolved question of whether OFC may discuss information it obtains from DSS with placement agencies licensed by OFC, when abuse is alleged to have occurred in a foster home approved by the placement agency. While G.L. c. 119, s. 51B(9) authorizes DSS to provide OFC with such reports of abuse, the statute is silent on the ability of OFC to show or discuss these reports with the private agencies it licenses. Other agencies permitted to receive information under s. 51B(10) also face this question.

Recommendation

The Panel believes that it is clearly to the benefit of children for OFC and other agencies to be able to discuss reports of child abuse with their licensees or providers and recommends that:

- o G.L. c. 119, s. 51B(9) and (10) be amended to permit the OFC Commissioner and other agency heads to share information they obtain from DSS with their licensees or contracted providers when such information is relevant to licensure or other statutory responsibilities of such agencies or when it is in the best interest of the child. Just as state agencies receiving 51B reports should maintain this as confidential information, secondary dissemination by licensees or providers should also be prohibited.

Other Information-Sharing Problems

The Panel also identified other problems with the exchange of information about foster children which appeared to create an impediment to services or to inadequately protect children from risk of harm. It appeared that these problems stemmed from misunderstandings about sharing of information, rather than actual legal barriers.

- . Foster parents sometimes feel they do not obtain adequate information from DSS about children placed in their homes because social workers are uncertain about how much they are legally permitted to share with foster parents;
- . Staff in some DSS area offices appear to be uncertain about their ability to share information with other DSS area offices; and

- . Private foster care placement agencies sometimes are not informed or are informed at a late date by DSS of the outcome of 51A reports filed involving foster parents approved by the agency.

Recommendations

- o DSS should clarify for social workers which information should be made available to foster parents under 110 CMR 7.112;
- o DSS should provide training to all area offices to clarify that DSS area offices may freely exchange information about DSS clients; and
- o DSS should develop procedures for promptly notifying private foster care placement agencies of the outcome of 51A reports filed concerning foster parents approved by the private agency.

III. PROTOCOLS IN CASES OF CHILD DEATH AND SERIOUS INJURY

The Panel reviewed the existing systems for reporting of deaths of children receiving services and for investigation of such deaths and made the following recommendations:

Reporting

Under DSS regulations and policy, all deaths of children known to DSS, including deaths of children in cases closed by DSS within the last six months, must be reported to the DSS central office Case Investigation Unit (CIU).

In addition, per EOHS policy, DSS and other EOHS agencies are required to report to the EOHS Investigative Unit the deaths of any human service clients receiving services from these human services agencies.

Recommendation

- o DSS should review its internal reporting system to continue to ensure compliance with its regulations and policy and, in consultation with EOHS, to ensure that all such reports are made in a timely manner consistent with EOHS policy.

Investigation

Since its inception in 1980, DSS has had a central office Case Investigation Unit (CIU) which performs a critical role in reviewing cases where a child known to DSS has died. The CIU conducts internal, confidential reviews of case files, interviews DSS staff and provides a factual accounting of events relating to the circumstances of the death and the Department's provision of services to the family.

The central mission of the recently created EOHS Investigative Unit is to oversee investigations by EOHS agencies of unexplained or suspicious client deaths or serious client injuries and, whenever possible, to strengthen agency investigation capabilities through training and direct involvement in specific cases.

The purpose of an OFC investigation is to determine if there were violations of any OFC regulations relative to the death or serious injury.

Recommendations

- o Current DSS regulations and policies concerning the Case Investigation Unit should be reviewed, in consultation with the EOHS Investigative Unit;
- o OFC protocols for investigations should be applied to the review of all deaths and serious injuries which occur in any OFC licensed or approved agency; and
- o The review should focus on the existing CIU practices for conducting investigations, including a determination of whether the normal scope of CIU investigations is adequate and properly focused. For example, in certain cases, the CIU may wish to expand the network of individuals interviewed beyond DSS staff to include family members, neighbors and others. In addition, the standard format for written reports should be reviewed to determine if that format appropriately highlights findings which require a prompt response of corrective action for protection of other children known to DSS. Also, other standard investigative techniques such as a requirement that investigators maintain written interview report summaries should be reviewed and where required incorporated into standard CIU protocol.

Department of Social Services - Area Office

Current DSS regulations state that the area office will contact the regional office in the event of a child's death. The regional office will in turn contact the central office Case Investigation Unit. The area office makes a copy of the case record to send to the CIU to prepare for the investigation. There are no specific policies or protocols delineating the responsibility of the area office in dealing with staff, providers, natural and foster parents. The basic issues of assessment of risk to other children in the home, grief counseling, notification of biological families, etc., have been left to each area to handle on an individual basis. The Panel acknowledges that each situation must be handled sensitively, and that the area office knows the family and situation best. However, the Panel has identified the need for DSS to develop specific protocols in this area.

Recommendations

- o Within 60 days, DSS should develop a written protocol for area office response when there is a death of a child in foster care. The protocols should outline the required procedures and notices, the staff responsible for implementing recommendations, and the timelines. In cases where DSS has contracted with private agencies to provide complete casework services, staff from such agencies should be included where appropriate. The following minimum criteria should be included in the protocol:
 - . a meeting convened within 24 hours of the death by the area director which includes relevant DSS and collateral staff;
 - . an assessment by the area director of the immediate risk to other children in the foster home, both natural and other foster children, and including, when circumstances warrant it, a visit to the foster home;
 - . notification of natural parents;
 - . an assessment of the need for grief counseling and other support services to both natural and foster parents;
 - . a review to assure that funeral arrangements are complete; and
 - . a review to assure that notices to proper agencies and offices has been completed; and
- o In the case of serious injury, the area director should decide if the protocols used in the event of the death are warranted at this time. If a decision is made to handle the incident in that manner, the same protocols should be employed.

CONCLUSION

The Panel, in a short period of time, attempted to review and make recommendations about the most pressing issues facing the Commonwealth's foster care system. While the Panel found that the system has been substantially strengthened over the past few years and is recognized nationally as one of the best systems in the country, it nonetheless identified some areas where further improvements were needed.

This report should be considered a beginning pending the outcome of the inquest now underway. Regardless of the outcome, however, the Panel believes that the recommendations presented should be implemented as soon as possible.

APPENDIX

FOSTER CARE ADVISORY PANEL LIST OF MATERIALS

I. INFORMATION REGARDING OFFICE FOR CHILDREN

Massachusetts General Law Chapter 28A, which is the enabling statute for the Office for Children. This first paragraph speaks to the Office for Children Authority to approve the Department of Social Services as a placement agency.

OFC Regulations regarding standard for the licensure or approval of agencies placing children into family foster and group care.

Interagency agreement between the Office for Children and the Department of Social Services. this addresses sharing of information between the agencies regarding allegations of abuse or neglect at any facility subject to licensure or approved by the Office for Children.

Massachusetts General Law Chapter 119, Section 51B, Section 9 mandates the Department of Social Services to notify Office for Children in writing when a 51A (report of abuse or neglect) has been substantiated alleging abuse or neglect has occurred at a facility subject to licensure or approval by the Office for Children.

Questions for Commissioner Leonard

II. INFORMATION REGARDING DEPARTMENT OF SOCIAL SERVICES

Massachusetts General Law Chapter 119 - 51E and 51F regarding confidentiality of Department of Social Services records.

Department of Social Services Policy regarding Case Investigation unit.

Interagency Agreement between the Department of Social Services and the Office of Chief Medical Examiner. This addresses statutory and regulatory responsibility of the Department of Social Services in cases where abuse or neglect is suspected. Information sharing between the agencies is clarified. Also there is an agreement to have joint training sessions.

Interagency Agreement between the Department of Social Services and the Massachusetts Society for Prevention of Cruelty to Children. This addresses the placement responsibilities of both agencies under FTE contract model.

- * Department of Social Services Management Reports:
These are printed monthly for each area office and indicates when a particular form or service is done, they include:

Social Worker Health Care Summary
Foster Care Homestudy Statutes
Timeliness of Investigations
Foster Care Review Data
Area Based Case Review
Assessment and Service Plan Timeliness
Overdue Reevaluation of Foster Homes
Adoption Homestudy Statuses Summary
Timeliness of Investigation done by contracted agency
Consumers entering, changing or leaving placement for the month.

- * Department of Social Services Case Practice Policy and Procedures Manual.

- * Department of Social Services EPRS job descriptions for:

Investigative Worker
Program Development Specialist
Assistant Program Development Specialist
Family Resource Adoption Worker
Social Work Technician
Homeless Specialist

Department of Social Services EPRS job description for:

Supervisor
Generic Social Worker

Questions for Commissioner Matava

III. INFORMATION REGARDING FOSTER CARE

Department of Social Services EPRS job descriptions for:

Family Resource Homefinder
Family Resource Homefinder
Case Reviewer

Statute creating Foster Care Review Unit

- * Special Commission on Foster Care

DSS Policy regarding Foster Care Review Unit.

Boston Globe editorial May 15, 1988 pp. 90 regarding Foster Care.

* Department of Social Services MAAP Training Manual.

* Sample Foster Care Review Unit Report.

IV. ACCESS TO INFORMATION

Chapter 66A Fair Information Practices

EOHS Fair Information Regulations

House Bill 131 - authorizing access by EOHS to information in the possession of Human Service Agencies.

Please note: * indicates materials not distributed but available for review by Panel members.

